Bureau of Quality Improvement Services
Community Vocational/Habilitation Survey

Provider Agency Name:	Address:	Contact Names & telephone numbers:

Individual whose Services are being Surveyed: _____ Social Security Number_____/_____/_____
Date of Survey: ____/____/_____ Time of Arrival: _____am pm Time of Departure: _____am pm

Setting: ☐ Waiver 24/7 staffing ☐ Waiver less than 24/7 staffing ☐ Waiver residing with family ☐ State Line Item Only ☐ Foster Care Adult/Child

If on Waiver, check type of Waiver: ☐ Autism Waiver ☐ DD Waiver ☐ Support Services Waiver

Date of most recent Plan of Care: _____ Attach copy

BDDS Service Coordinator: _____ District #_____

Lead Quality Monitor/Quality Coordinator _____ Second Quality Monitor: _____

Lead person is responsible for data entry, filing of incident reports and follow up scheduling of this report)

Upon arriving at the provider, identify self as an Employee with the Bureau of Quality Improvement Services (provide ID card if requested) and state your purpose for visiting (i.e. to perform an annual provider survey for BQIS).

Note any problems with being allowed into the provider below, and notify supervisor before end of same business day. If no problems, enter "NA".

_____

Names & Positions of staff present and working with individual:

_____ (Name / position)	_____ (Name / position)	_____ (Name / position)
_____ (Name / position)	_____ (Name / position)	_____ (Name / position)

Review of Paperwork/Documentation

1. Is provider accredited by one of the following organizations? If yes circle which one IAC 6-5-6 (2)	YES NO	♦ The Commission on Accreditation of Rehabilitation Facilities or its successor ♦ The Council on Quality and Leadership in Supports for People with Disabilities or its successor ♦ The Joint Commission on Accreditation of Healthcare Organizations or its successor ♦ The National Commission on Quality Assurance or its successor ♦ An independent national accreditation organization approved by the secretary
2. Is staffing correct at time of survey?	YES NO	Note any Concerns:
3. Is there a current ISP for the individual? IAC 6-10-7 (a)	YES NO	Note any Concerns:
4. Has provider implemented the medication administration system designed by the individual's provider responsible for medication administration? IAC 6-10-7(c)	YES NO N/A	Note any Concerns:
5. Has the provider implemented the seizure management system designed by the individual's provider responsible for seizure management? IAC 6-10-7(d)	YES NO N/A	Note any Concerns:
6. Has the provider implemented the health related incident management system designed by the individual's provider responsible for health-related incident management? IAC 6-10-7(e)	YES NO N/A	Note any Concerns:
7. Has the provider implemented the behavioral support plan designated by the individual's provider of behavioral support services? IAC 6-10-7 (f)	YES NO N/A	Note any Concerns:
8. Is the provider following the specialized diet program designed by the provider of nutritional counseling services, including any documentation requirements contained in the individual's dining plan? IAC 6-26-1 (d)	YES NO N/A	Note any Concerns:

9. Is there documentation that includes: Date and amount of time spent with individual Location of services Type of Services Description of activities Signature of Staff who provided services (6-17-3)	YES NO	Note any concerns:
10. Is the documentation and environment free of any evidence that a reportable incident may not have been reported? (6-9-5)	YES NO	**Incident report stating "The following reportable items were seen during a BQIS Survey" required for all "NO" answers.** Provide the details of the reportable incident both here and in Incident Report:
11. Is there documentation of ISP outcomes and progress made toward achieving those outcomes present? (6-17-3)	YES NO	Note any concerns:

INDIVIDUAL INTERVIEW SECTION

Individual is: ÿ **able to communicate answers to questions** ÿ **non-communicative**

- Communicate with the individual whenever possible. If the individual is non-communicative, indicate below the person acting as the main respondent by checking the appropriate selection:

paid caregiver ÿ family member ÿ guardian ÿ other ÿ (specify relationship to individual)_____

Individual Rights/Respect

12. Do staff treat you with respect and ask you what you want when appropriate? IAC 6-9-3 (a)	YES NO	Note any concerns:
13. This question is not to be asked in the presence of provider (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with your provider? Do the people who help you treat you the way you want to be treated? IAC 6-8-3	YES NO	Note any concerns:

14. (NOTE: For 4a, 4b & 4c - if individual is non-communicative make note to that effect and mark sections NA (caretaker will be questioned later in survey regarding these safety issues) What do you do... " (6-29-6)	♦ "If there is a fire"?	YES NO NA
	♦ "If there is a tornado warning"?	YES NO NA
	♦ "If you smell gas"?	YES NO NA

15. "What plans or activities does the staff help you with"? List activities provided in response: ♦ ♦ ♦ (6-24-1 & 2)	List additional plans/activities as included in the record:	Compare to ISP and note any concerns:

Safety and Environmental Requirements

16. Is this provider's interior and exterior free of any health and safety concerns (real risks for injury, infection, disease, etc.)? If "NO" describe the specific issue, and provide specific details of each concern. (6-29-2)	YES NO	Specific health/safety concern observed	Detailed, specific reason/s this issue is being identified as risk to health and safety:
		♦	♦
		♦	♦
		♦	♦

Staff Interview Section

		Record specifics of staff response. "YES" marked only for competent, correct responses:	Note any concerns:
17. "Do you know what universal precautions are? Please tell me how you utilize them on the job". (i.e. – what steps do you take if you need to clean up blood)? (6-14-4)	YES NO		
18. "Are you familiar with the signs and symptoms of seizure activity, including any aura prior to a seizure? What are they"? (6-14-4)	YES NO		

19. "How would you document a seizure?" Ask specifically and view the documentation to assure that documentation includes activity before, during and after the seizure. (6-25-7)	YES NO		
20. "Do you know the individual's diet needs, including how to prepare their food? Please tell me about the individual's diet needs." (6-14-4)	YES NO		
21. "Are you aware of possible side effects of the individual's medication? What are they?" NOTE: "NA" only if on no medications (6-25-6)	YES NO N/A		
22. "Have you been trained in the individual's behavior management plan? What are the targeted behaviors and interventions used?" NOTE: "NA" only if no behavior plan in the ISP (6-14-4; 6-18-2)	YES NO N/A		
23. "If manual restraints are used, have you had training in non-injurious aggression management techniques?" NOTE: "NA" only if on no manual restraints used and/or none in ISP. (6-18-2)	YES NO N/A		
24. "Do you know how to report an incident per the BDDS incident reporting procedure?" **(Includes knowing the types of reportable incidents and knowledge that they have the ability to independently report incidents to APS/CPS.)** (9-9-5)	YES NO		

25. "What do you do…..": (staff should be able to state how to exit/take shelter, along with precautions to take and who to contact) Response is not competent if the staff indicates that they would phone for emergency assistance prior to leaving the provider for fire or smelling gas. (6-14-4)	a. "If there is a fire?" (document response)	Does response present a concern? YES NO
	b. "If there is a tornado warning?" (document response)	YES NO
	c. "If you smell gas (NA only is there is no gas utility service connected to the home?" (document response)	YES NO N/A

Questions in this section are addressed to and should be answered by the BQIS staff person performing this survey:		
26. Is this visit and survey free of any observed or evidence of abuse, neglect or exploitation?	YES NO	If "NO", file an incident report. Make decision on need to implement the BQIS IMINENT DANGER POLICY based on facts. Contact supervisor and provide update on filing of incident report, any other policy implementation, and get consensus on appropriate immediate action. Summarize findings and actions taken:
27. Is this visit and survey free of any observed heath or safety concerns for this individual not documented in the questions listed above that do not meet the BDDS Incident Reporting criteria? (not serious enough to require an incident report or implementation of imminent danger policy)	YES NO	If "NO", describe in detail:

Survey summary – Corrective Action plans vs. concerns needing attention

For each item in survey identified with a concern, indicate appropriate action needed by service provider in tables below

Survey items requiring follow-up by BQIS

Item #	Brief description of concern & recommended method of confirming compliance (ex. re-visit home; receipt of verification documents; etc)	provider

Survey items requiring informal attention by provider

Item #	Brief description of concern	provider

Surveyor signature

"I attest that this survey is an accurate account of findings based on my observations on the date and time indicated"

Lead Surveyor; _____ _____ _____

Signature Title Date Signed

For additional notes, attach sheets/documents as necessary